



## CONSENT TO PHYSIOTHERAPY TREATMENT AND THE PRICE

I, \_\_\_\_\_, hereby authorize and agree to participate in the initial assessment(s) and the subsequent treatment programs at TOP REHAB for my present condition(s). I understand that my treatment program at TOP REHAB may consist of physical and fitness assessment, re-assessment, education, therapeutic modalities (i.e. ultrasound, laser, electrotherapy, heat / cold therapy etc.), manual therapy, acupuncture, postural correction and energy conservation education, therapeutic exercises, conditioning exercise program, functional training etc.. I understand and agree that such mentioned services above may be administered by the registered physiotherapist, chiropractor or the support staff (i.e. the physiotherapy assistant) under the supervision/prescription of the physiotherapist and/or chiropractor.

I understand that the assessment and the treatment program will be provided as they are deemed necessary by the appropriate health practitioner. I understand that results are not guaranteed. I understand that there are some risks (i.e. cardiovascular and musculoskeletal) associated with the treatment program, although rare, and are not limited to sprains / strains, fractures and burns from modalities. I understand that in the practice of acupuncture, there are some risks to treatment, including but not limited to, minor bleeding, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles. These acupuncture treatments are not necessarily part of every patient’s course of therapy and they would only be performed after consultation with you.

I do not expect the health practitioner to be able to anticipate and explain all risks and complications and I wish to rely on the physiotherapist, chiropractor, or the physiotherapy assistant to exercise judgement during the course of the treatment program which he/she feels at the time, based upon the facts then known, is in my best interest.

I understand it is my responsibility to fully disclose any of my known medical conditions and all relevant information regarding my condition(s), as well as medications recently taken at the assessment and throughout the course of the treatment program at TOP REHAB in order to minimize risk. I understand that it is also my responsibility to inform my treating health practitioner or the support staff, at any time, if I feel that any activity during the course of the treatment program may put me at risk for injury.

I have had an opportunity to discuss with the treating physiotherapist, chiropractor, the support staff, the clinic manager and the other staff at TOP REHAB regarding the above-mentioned assessments and treatment program. I understand that I am free to stop the assessment and the treatment program at any time if I so choose. My permission to perform such assessments and treatment program at TOP REHAB is given willingly.

I have reviewed the TOP REHAB’s Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

Initial Physiotherapy Assessment and Treatment	\$120		
Physiotherapy Follow-up Single Treatment	\$90	Physiotherapy Follow-up Double Treatments(two areas)	\$100
Pelvic Health physiotherapy Initial (female client)	\$150	Pelvic Health Follow up (female client only)	\$120

I have read this consent form and I understand it, the price above and I agree to pay, and any questions, which may have occurred to me, have been answered to my satisfaction. By signing below, I consent to participate in the above mentioned assessments and treatment program. I understand that my consent can be withdrawn at any time, but I intend for this consent form to cover the entire course of the assessments and the treatment programs at TOP REHAB(unit 11B 512 Bristol Rd West, Mississauga, ON L5R 3Z1)

**Dated at the city of Mississauga this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_